enlarged prostates are most likely to benefit from finasteride in terms of improvements in symptoms and flow rates.[4] This is consistent with its mode of action, which is based on reducing prostate volume. Since Jacobsen et al's epidemiological study confirmed that men with enlarged prostates were at greater risk of developing acute urinary retention, it would seem logical therefore that the most cost effective way of achieving the additional benefits identified in McConnell's study is to use finasteride mainly in men with enlarged prostates.

This leads us to define a practical approach to use finasteride selectively in the right patients. It is unrealistic to suggest that all men with lower urinary tract symptoms undergo transrectal ultrasound to assess the size of the prostate. A simpler approach is to estimate prostate size from a digital rectal examination (which should be carried out in these men anyway to help exclude the presence of prostate cancer). A study comparing the use of digital rectal examination and ultrasound to assess prostate size concluded that doctors performing digital rectal examinations tended to underestimate the size of the prostate. Thus a pragmatic interpretation of the digital examination should be: "If it feels big, it is big." This straightforward technique would facilitate implementing these recent findings into practice in both primary and secondary care.

Now for the first time in benign prostatic hyperplasia we have evidence that appropriate medical intervention can be used to provide a complete management strategy. Unlike other therapeutic areas such as hypertension or hyperlipidaemia, where such interventions may be used solely to achieve a long term goal, we have the opportunity both to provide symptomatic relief, the principal short term goal, and to reduce long term complications.

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Competing interests—RK has spoken at symposiums on behalf of pharmaceutical companies that manufacture products for treating benign prostatic hyperplasia.

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Changing practice in growth monitoring

No evidence exists that monitoring height velocity is useful

The French pay child benefits only on production of a school medical certificate confirming that height measurements are up to date. If the French, why not the British? Height is easily measured, and height velocity is claimed to be a sensitive index of many disorders, genetic, metabolic, and psychosocial. More than just a marker for health, growth could be a useful tool for picking up silent disease. All that we lack is the evidence.

The dilemma of pursuing a screening programme based on a scientifically plausible but unproved hypothesis has recently been raised.[1] In particular, the use of growth data to screen for silent disease in children has been the subject of lengthy debate, but there have been few cohort studies on which to judge its effectiveness, and consensus guidelines for referral have yet to emerge. Much of the debate currently relies on evidence from the Wessex growth study, which since 1986 has monitored a cohort of very short children in the community.[2] This study has been unable to show the ability of repeated height measurements to identify new disease, has found height velocity to be unreliable, and has concluded that height screening at school entry is the best means of identifying silent disease in school age children.

Stature alone can be a simple and useful index of disease. Further investigation of the 147 children from the Wessex growth study who had been passed as "short normal" at school entry identified eight cases of previously unidentified disease.[3] In only four was it remediable, but in all it was informative. Predictably, the proportion of children with organic disease increased with the degree of short stature. Use of the new 0.4th instead of the third centile should reduce to a minimum the numbers referred, but this has to be weighed against missed diagnoses. Indeed, two of the eight cases of silent disease in the Wessex cohort lay above the current 0.4th centile cut off for referral at school entry.

In less extreme cases of short stature referrals are sometimes controlled by a "wait and see" policy, using height velocity, often over a very short period, as a secondary screening tool.[4] Children apparently growing well can then be dismissed and the rest referred for specialist advice. Growth hormone therapy may even be started on the basis of the auxological data.[5]

Height measurement is inevitably imprecise.[6] It is unlikely, a priori, that velocity—which is not measured but only derived from height measurement—could be more informative. The Wessex study has clearly shown that, while successive heights are highly correlated, successive 12 month velocities are not.[7] Velocity thus fails both to reflect previous growth and to predict future growth. Its interpretation is further complicated by the variable onset of the pubertal growth spurt and the fact that "satisfactory" growth, at any age, is conditional on height and age.[8] The evidence is that the height velocity chart, often promoted as a better means of evaluating growth than height chart alone, has no place in community paediatrics.

The insecurity felt by many in abandoning familiar measures is understandable. In addition to the short children, however, the Wessex study has followed a cohort of 140 average height controls over the past 12 years. Only three have acquired disease—two diabetes

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and one hypothyroidism. At no time did the growth of either falter, nor did any of the remainder of the cohort cross a height centile band, at least not before puberty. This should lay to rest any concern that important new disease will be missed after the age of 5 without further measurements. The most recent guidelines concede that velocity estimates are unreliable but nevertheless propose that the height charts of short children should be checked for movement across centile bands.[9] The evidence, however, is that the sensitivity and specificity of these measures in identifying silent disease is inadequate.[10]

It remains unclear whether more frequent height checks from infancy, a greater awareness of signs and symptoms other than short stature, or a single measurement of height would best identify growth related disease. The evidence so far suggests that the single measurement at school entry is the most sensitive anthropometric marker for silent disease.[3] At that age very short stature must result from sustained slow growth. Further proof of growth failure is unnecessary and any concern about disease missed is best addressed, not by awaiting additional measurements, but by improving clinical acumen. Short, but otherwise healthy, school entrants can also be reassured that they are no more likely to become ill than their taller peers.[8]

To be spared repeated height checks in school would come as a relief to many. The debate will undoubtedly continue unless resolved by a large scale prospective community study. Until then there is no evidence that growth monitoring, as opposed to height screening, is a cost effective use of scarce resources.

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Evidence based mergers?

Two things are important in mergers: clear goals, clearly communicated

The NHS seems to be in the grips of "merger mania." Why is this happening and why now? More importantly, on what basis do we judge whether the merger of two or more NHS organisations is successful and is there an evidence base on how to manage them?

Seventeen mergers of NHS trusts took place in England in 1991-7.[1] The cycle of trust establishment and merger activity follows the NHS financial year. Twenty three mergers came into effect from 1 April 1998, and ministers are considering further proposals for April 1999. In Scotland's current "reconfiguration" the number of trusts is planned to reduce from 47 to 26, and in Wales 26 trusts will be reconfigured into 16 by April 1999. The government sees these mergers as "evidence of a new cooperative culture developing inside the NHS." Laudably the key test that will be applied in judging the merits of merger proposals will be whether they improve patient care. All will also have to lead to proved reductions in bureaucracy.[2]

Mergers occur in mature industries because of trends such as globalisation, increased competitiveness, and government deregulation policies: thus many examples exist in the airline, telecommunications, pharmaceutical, and utility industries. The last government's introduction of the internal market into the NHS and associated deregulation, albeit mild, stimulated merger activity in the early 1990s. Certain trust mergers in London were perceived as "shotgun marriages" forced by the Tomlinson report—a government intervention in a market place which was beginning to take hold and to wound major teaching hospitals.

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Other than edict, what are the reasons for merger? Clearly there are economic reasons. Economies of scale (operating efficiently at higher rather than lower levels of production) and economies of scope (centralising multiple services to ensure critical linkages) are both often cited as rationales. Merger is also a legitimate device to deal with excess capacity in the local health economy, as evidenced by many proposed mergers resulting from reconfigurations of acute services within a whole health authority area. The "concentration" of services on one site is also driven by the reform of medical staff training, reduced hours of working for junior doctors, the trend towards subspecialisation, and in some cases by national service guidance such as the Calman-Hine recommendations on cancer services; we can expect more of the last sort through the national service frameworks proposed in the English white paper on the NHS.[3]

During early 1995 the pursuit of power in the marketplace could have been cited as a powerful reason for merger; now it is truer to say that the power which accrues from being a substantial player on the local health scene has become the goal—in order to attract and keep staff, raise capital, and work flexibly across multiple services. Finally, the downward pressure on management costs is a further factor. Mergers offer organisations potentially large savings on senior management positions and board structures.

What is the evidence about the outcome of mergers in the health sector? As with the commercial world, very few data exist. A recent economic review states, "The evidence of the impact of mergers in the health